SJOT

Student Journal of Occupational Therapy

Volume 2 | Issue 1 Article 3

2021

The Relationship Between Alternative Fieldwork Approaches and Student Competence and Confidence for Occupational Therapy in Behavioral Health

Kathryn Beckstein
Huntington University, becksteink@huntington.edu

Elizabeth Britton
Huntington University, brittone@huntington.edu

Codee Colby
Huntington University, colbyc@huntington.edu

Kathleen Melei
Huntington University, meleik@huntington.edu

Emily Rehmel
Huntington University, rehmele@huntington.edu

See next page for additional authors

Recommended Citation

Beckstein, K., Britton, E., Colby, C., Melei, K., Rehmel, E., & Best, S. (2021). The Relationship Between Alternative Fieldwork Approaches and Student Competence and Confidence for Occupational Therapy in Behavioral Health. *Student Journal of Occupational Therapy, 2*(1), 21-51. https://doi.org/10.46409/001.BWXS8816

The Relationship Between Alternative Fieldwork Approaches and Student Competence and Confidence for Occupational Therapy in Behavioral Health

Authors

Kathryn Beckstein, Elizabeth Britton, Codee Colby, Kathleen Melei, Emily Rehmel, and Sara Best

Author(s) ORCID Identifier:

Kathryn Beckstein: https://orcid.org/0000-0002-7831-3993

Elizabeth Britton: https://orcid.org/0000-0001-9803-4628

Codee Colby: https://orcid.org/0000-0001-7856-8075

Kathleen Melei: https://orcid.org/0000-0002-1503-1032

Emily Rehmel: https://orcid.org/0000-0003-0909-2442

Sara Best: https://orcid.org/0000-0003-2240-405X

Student Journal of Occupational Therapy, *2*(1), 21-51

The Relationship Between Alternative Fieldwork Approaches and Student Competence and Confidence for Occupational Therapy in Behavioral Health

Kathryn Beckstein Elizabeth Britton Codee Colby
Kathleen Melei Emily Rehmel Sara Best

Huntington University

DOI: https://doi.org/10.46409/001.BWXS8816

To cite this article:
Beckstein, K., Britton, E., Colby, C., Melei, K., Rehmel, E., & Best, S. (2021). The relationship between alternative fieldwork approaches and student preparedness for occupational therapy in behavioral health. *Student Journal of Occupational Therapy*, *2*(1), 21-52. https://doi.org/10.46409/001.BWXS8816

Author Note: We have no known conflict of interest to disclose. Our work was supervised by Dr. Sara Best, OTD, CAS and Dr. Kathleen N. Bergman, PhD.

Abstract

Purpose*: The purpose of this case-series study was to assess the relationship between three instructional methods that fall within the parameters of the revised Accreditation Council for Occupational Therapy Education fieldwork objective C.1.9 and perceived student competence and confidence in providing therapy services in a behavioral health setting.*

Methods*: The study included a convenience sample of (n=49) graduate students enrolled in an entry-level Doctor of Occupational Therapy program and a Doctor of Physical Therapy program in the Midwest. The participants attended a presentation on bipolar disorder and were randomly assigned to engage in one of three instructional methods: (a) lived experience academics, (b) problem-based learning, and (c) standardized patients to further learn about bipolar disorder.*

Results*: Analyses revealed no significant interaction effects on competence across instructional methods but did reveal significant main effects of group and time on confidence. Confidence increased across all instructional methods and exhibited a significant difference between the lived experience academics and standardized patient.*

Significance*: The study results demonstrate a need for further research on how to best prepare occupational therapy students for behavioral health settings.*

Keywords*:* confidence, competence, behavioral health, psychosocial, occupational therapy, student preparedness, fieldwork, lived experience academics, standardized patient, problem-based learning

Introduction

While occupational therapy (OT) practitioners now work in a wide variety of settings with individuals across the lifespan, the foundation of the profession embodied mental health as a valued component of practice (Brown & Stoffel, 2011; Creek & Lougher, 2008). Psychiatrists and physicians of institutions allowed participation in tasks such as gardening and crafts after identifying individuals experiencing depression and other mental health ailments displayed fewer symptoms when engaged in meaningful activities (Creek & Lougher, 2008). Today, OT interventions target cognitive impairments; sensory needs; and difficulties with activities of daily living (ADLs), instrumental activities of daily living (IADLs), and social interactions (Swarbrick & Noyes, 2018). Despite the identified role of OT in mental health, the American Occupational Therapy Association (AOTA) (2019) reports that as of 2014, only 2.4% of OT practitioners work in mental health settings. A limited pool of OT practitioners may pose as a barrier in obtaining clinical fieldwork experience within mental health settings.

To meet the need for more fieldwork experiences within mental health, the 2020 Accreditation Council for Occupational Therapy Education (ACOTE) standards included revisions for C.1.7, which currently require at least one fieldwork experience (either Level I or Level II) to address practice in behavioral health or psychological and social factors influencing engagement in occupation (ACOTE, 2018). The council also revised standard C.1.3 to include a psychosocial objective to all fieldwork experiences. Lastly, a revision of fieldwork objective C.1.9 was included, expanding the current Level I fieldwork experiences to include additional instructional methods, such as simulated environments, standardized patients, and faculty practice (AOTA, 2019).

As mentioned above, the changes to fieldwork requirements expand OT programs' ability to create individualized Level I experiences to best prepare students to provide OT services in behavioral health settings. According to Knecht-Sabres et al. (2013), "[OT] programs prepare students for practice through didactic course work, experiential learning opportunities, and fieldwork . . . OT academic programs have modified the curricula to better prepare students to address the current demands of fieldwork and clinical practice" (p. 1). The current study assessed the relationship of specific instructional methods that satisfy the ACOTE Level I requirements and student preparedness for fieldwork and clinical practice, specifically the outcomes involving competence and confidence in understanding the role of OT practitioners in mental health.

Occupational Therapy and Mental Health

The expansion of fieldwork objectives further asserts the role of OT in mental health by differentiating between psychosocial and behavioral health. Throughout education and fieldwork, *psychosocial* is an "interrelation of behavioral and social factors" (Martikainen et al., 2002, p. 1091). Whereas, *behavioral health*, the historical foundation of OT, "refers to mental/emotional well-being and/or actions that affect wellness" (Substance Abuse and Mental Health Administration, 2014).

According to the National Board for Certification in Occupational Therapy (NBCOT) (2018) executive summary of the 2017 practice analysis, 46.8% of OT practitioners who provided psychosocial services reported addressing anxiety, 36.5% addressed behavioral disorders, and 20.3% addressed mood disorders. The OT practitioners who participated in the NBCOT study were in the field for three years or less (NBCOT, 2018). Blackwell and Bilics (2017) found that while programs address the role of OT in schools and mental health settings, students report limited experiential learning opportunities. With limited experiential learning and few OT practitioners working in mental health settings, programs need to provide additional instructional methods regarding behavioral health.

Educational Philosophy for Preparing Students in Behavioral Health

Limited experience and exposure to OT practice

https://doi.org/10.46409/001.BWXS8816

within behavioral health settings inhibit the OT profession's ability to progress toward an increased prevalence of practitioners working in behavioral health settings. Ikiugu and Schultz (2006) discussed the "identity problems" many OT practitioners struggle with amidst unclear expectations and occupation-based goals. Breines (1987) suggests that OT programs must recognize that curricula should change and adapt while also maintaining the profession's foundational beliefs and principles. OT programs can provide a more comprehensive definition of OT and professional identity by maintaining the balance between curriculum development and the profession's foundations. (Breines, 1987). Thus, the recent opportunity to expand level I fieldwork requirements poses a unique opportunity to define OT practitioners' role in mental health.

The philosophy of pragmatism serves as a useful tool for OT programs to guide students' education and practice in behavioral health. Breines (1987) suggested the educational philosophy, values subjective experiences within one's environment to apply and test ideas that can lead to social or personal action. While fieldwork experiences cultivate a lived, subjective experience, they must also provide a supportive environment to put ideas into action and interact with "both human and non-human" components (Ikiugu & Schultz, 2006, p. 92). OT programs facilitate student preparedness by using various traditional and alternative fieldwork experiences based on the aforementioned educational philosophy.

Fieldwork

Programs must evaluate current fieldwork experiences before considering additional instructional methods to maximize students' clinical skill development. Primary challenge areas for students included critical thinking and responding, engaging in hands-on technical skills, and adjusting to the fast pace and complexity of clinical practice (Knecht-Sabres et al., 2013). A study conducted by Crowe and Mackenzie (2002) evaluated the importance of the OT student fieldwork experience. The initial research found that individuals who had a positive fieldwork experience were more likely to explore careers in that specific population and setting (Crowe & Mackenzie, 2002). However, students were less prone to explore settings in which a negative fieldwork experience took place. Crowe and Mackenzie (2002) concluded with fieldwork playing an integral part in introducing students to practice areas, and potentially shaping their practice preference, the contribution of fieldwork experiences with academic curriculum should be further researched.

Value of Clinical Experience

Fieldwork plays a critical role in students' learning and career paths. Clinical practice is fundamental to education in providing students with opportunities to develop cultural awareness, professional reasoning, and technical skills (Rodger et al., 2011). However, providing readily available, standardized, measurable, and high-quality placements has been found to be difficult (Rodger et al., 2011; Quail et al., 2016). As a result, present research typically focuses on new fieldwork models to prepare students. Some research suggests placements—whether traditional, virtual, or simulated—all result in similar outcomes for students' communication skills, knowledge, and confidence (Quail et al., 2016). Similarly, Roger et al. (2011) suggested the type of placement did not determine the quality, but whether the placement met a variety of criteria. The criteria included optimal and individualized learning, therapist and student communication, feedback and support, and a balance between supervision and autonomy (Rodger et al., 2011).

Value of Alternative and Additional Fieldwork Experiences

Despite the value of clinical experience, evidence supports alternative or additional instructional methods to prepare students (Schaber et al., 2010; Rowe et al., 2012; McGee & Sopeth, 2015). *Blended learning* is the "systematic integration of online and in-person support between student, educator, [and] resources" (Rowe et al., 2012). Blended learning provides a wide variety of learning experiences such as small groups, web-based discussion boards, reading, online classes,

practical sessions, and out of class discussions. Studies have revealed that the use of blended learning equips students with the necessary experiences and resources to achieve desired outcomes (Rowe et al., 2012; McGee & Sopeth, 2015; Schaber et al., 2010). Though many models exist for clinical education, blended learning provides opportunities to use and explore a variety of alternative instructional methods such as: lived experience academics, problem-based learning, and standardized patients.

Lived Experience Academics

Lived experience academics (LEA) is one alternative instructional method that can be implemented as a model for clinical education. Ridley et al. (2017), defined LEA as "a form of expertise that represents a person's experience of mental distress, service use, and recovery" (as cited in Byrne, 2013, p. 372). A study conducted in Australia analyzed how social work students perceived mental health problems before and after the LEA session and how the students could apply LEA to clinical practice (Ridley et al., 2017). Students reported the LEA revealed a stronger understanding of recovery and acceptable terminology. Most students revealed the LEA redirected preconceived notions about individuals with mental health conditions (Ridley et al., 2017).

In Australia, interest is increasing on recovery-focused services within the mental health field (Happell et al., 2015). Research analyzed nurses and lived-experience educators' perceptions of the effects of LEA in Australian universities. Results revealed a primary theme of fear and power with three subthemes of facing fear, demystifying mental illness, and issues of power. Although there is a relation to fear and working with a mental health population, involving individuals with lived experience exposes students to the unique challenges that individuals face with mental health problems and recovery (Happell et al., 2015).

Problem-Based Learning

Another alternative instructional model is *problem-based learning* (PBL), based on real-life situations and allows students to gain competence utilizing resources, reasoning, and problem-solving skills (Scaffa & Wooster, 2004). Following a quasi-experimental study by Scaffa and Wooster (2004), the researchers identified a statistically significant increase in students' overall self-perception on clinical reasoning skills and behaviors as a result of PBL instruction. PBL requires students to evaluate clients' environmental contexts and personal components to encourage integrative learning as opposed to memorization (Scaffa & Wooster, 2004). According to Evenson (2011), PBL methods significantly increased with students' perceived confidence in searching and appraising research evidence in a client case analysis assignment (Evenson, 2011). Knecht-Sabres et al. (2013) found the use of standardized patients and problem/case-based learning activities can improve the students' readiness and preparedness for fieldwork and clinical practice.

Standardized Patient

Combining the approaches of problem-based learning and lived experience academics, the use of a *standardized patient* can be implemented. Standardized patients are simulated or actual patients who portray a specific condition or illness creating an opportunity for students to gain clinical practice through a simulated case. (Knecht-Sabres et al., 2013). Simulated environments allowed students to make mistakes in a nonthreatening environment and learn from the experiences (Knecht-Sabres et al., 2013). Students identified synthesizing information from clinical coursework and applying it to a medically complex simulated patient as a helpful method to prepare for Level II fieldwork and clinical practice (Giles et al., 2014). Standardized patients may be used to teach students communication and clinical skills (Quail et al., 2016). Overall, simulation using clinical interaction with a trained actor or a computer-generated virtual patient resulted in improved outcomes equal to traditional interaction with a live person (Quail et al., 2016).

Additional Instructional Methods, Confidence, and Competence

Ultimately, the goal of the LEA, PBL, and standardized patient methods are to equip students with both competence and confidence in clinical practice. Cohn (2019) referenced Land and Ross (1998), describing competence as an ability to complete a task effectively and to provide quality interventions (Cohn, 2019). The researcher further defined confidence as a mind-set related to self-efficacy, wholeheartedness, and action (Cohn, 2019). In her 2019 Eleanor Clarke Slagle Lecture, Ellen S. Cohn asserted the significance of competence and confidence for the profession of occupational therapy. She stated, "to communicate confidently the grand narrative of our competence, we need to be role models and mentors for each other. we must reinforce our belief in the value of occupation. . . take chances, and try something new" (Cohn, 2019, p. 9). This statement affirms the need to advocate for fieldwork experiences where OT practitioners' presence is limited, particularly in behavioral health settings. Cohn (2019) argued that competence is not what holds one back, but confidence. While many programs prepare students for competence, often preparation for fieldwork experiences do not focus on confidence development.

Programs that implement new, additional instructional methods may support the development of competence and confidence through providing a variety of individualized and unique experiences directly related to clinical practice. Pittman and Lawdis (2017) suggest online, multifactorial training increased students' level of confidence and competence with implementing interventions. Similarly, Dickinson et al. (2016) stated students who received a high-fidelity patient simulation in conjunction with a lecture demonstrated an increase in understanding, confidence, and competence of the given topics. With competence and confidence combined, students are empowered to problem solve, communicate, and advocate for the profession of occupational therapy. Further research is needed to explore the relationship between confidence, competence, and additional instructional methods such as the LEA, PBL, and standardized patients to prepare students for behavioral health settings.

Current Study

The current study aims to evaluate the relationship of an LEA, PBL, and use of standardized patients on student competence and perceived confidence to provide OT services in behavioral health settings. The literature suggests LEA, PBL, and the use of standardized patients are effective methods to benefit students' clinical reasoning skills, improved perceptions of performance, and overall interpersonal skills (Quail et al., 2016; Ridley et al., 2017; Scaffa & Wooster, 2014). However, limited research exists in applying alternative instructional methods within OT programs' curricula. The methods utilized within the study, overall, aim to create additional Fieldwork I opportunities for a Doctor of Occupational Therapy (OTD) program in the Midwest to successfully provide students with more diverse, accessible, and in-depth experiences in areas of emerging practice.

Methods

Participants

Following the approval of the institute's institutional review board (IRB), participants were recruited via flyers posted around campus, e-mails, and classroom presentations. Inclusion criteria consisted of a convenience sample of OTD and Doctor of Physical Therapy (DPT) students enrolled in selected programs in the Midwest who had not yet begun the Level II fieldwork OTD requirement or full-time clinical DPT internship. Exclusion criteria included any student who had started the Level II fieldwork requirement as an OTD student or the terminal full-time clinical internship experience as a DPT student. The inclusion and exclusion criteria were developed based on students' inability to utilize alternative instructional methods to fulfill the Level II fieldwork requirement; therefore, the inclusion criteria were limited to students who are currently able to benefit from alternative instructional methods.

Instruments

Pre-test and post-test questionnaires (see Appendix B & C) were developed based on information from multiple sources on OT and mental health. A pilot study was conducted with a current OTD student. The pre-test consisted of demographic data that asked participants their previous experiences in behavioral health, undergraduate degree, and fieldwork placements. Both the pre-test and post-test evaluated competence and confidence to assess student preparedness. Initially, the survey was accessed online, but during data collection, the survey had to be accessed through paper copies due to a system malfunction (see limitations). The participants' level of competence was measured using multiple-choice questions created by a registered OT practitioner. Students responded to ten Likert scale statements, rating their confidence along a five-point scale. Statements measured the level of confidence with various skills such as therapeutic use of self, developing a plan of care, and applying interventions.

Procedures

Participants were required to sign a consent form (see Appendix A) prior to participating in the research study and were informed that participation could be voluntarily terminated at any time. Participants were provided a schedule which included a timeline of the two-hour session and were then randomly provided a number that would evenly distribute them across the three instructional method groups. Based on participant volume, participants were randomly split into two different rooms to receive the lecture. Both lecture groups received the same lecture, read directly from PowerPoint notes, and explored OT practitioners' role in behavioral health and evidence-based interventions that addressed a bipolar disorder diagnosis. Following the completion of the lecture, participants completed the pre-test. Participants then attended their assigned instructional method, which further addressed the bipolar diagnosis covered in the lecture material. Participants received one of the following instructional methods: LEA, PBL, or a standardized patient. Following the 30-minute instructional session, the participants completed a post-test survey (see Appendix C), identical to the pre-test excluding demographic data.

LEA

An individual with personal experience living with a bipolar disorder diagnosis spoke to the participants over a virtual video call about the effect of the diagnosis on occupational performance. Participants listened to the individual's presentation and engaged in a question and answer session with the speaker.

PBL

A written case study was provided to the participants, which contained information about a hypothetical patient with a bipolar disorder diagnosis that resembled the LEA presentation. Participants read and analyzed the case study to develop a plan of care, including client factors, OT interventions, and potential therapeutic outcomes (see Appendix D).

Standardized Patient

A professional who had experience treating individuals with mental health problems emulated a hypothetical patient experiencing symptoms of mania during a simulated therapy session with an OT. The goal was to provide a simulated, hands-on, interactive experience for students to receive participant feedback and correspondence during the session. Information provided to students during the simulation reflected that of the LEA. Participants analyzed the information provided by the standardized patient and developed a plan of care, which included client factors, suggestions for OT interventions, and potential therapeutic outcomes (see Appendix E).

Results

A total of 49 students participated in the study, providing a convenience sample of primarily female (n = 45), OTD students. The majority of the participants (n = 46) were between the ages of 22 and 25 years. The top four represented

Table 1.
Percentage of students per cohort.

2021 Fall Cohort	2021 Spring Cohort	2022 Fall Cohort	2022 Spring Cohort	DPT Students	Unanswered
28.57%	12.24%	32.65%	18.36%	6.12%	2.04%

Table 2.
In what setting did your Level I psychosocial fieldwork rotation take place?

Inpatient/Outpatient Mental Health	Community	Not Applicable
10.20%	34.69%	55.10%

Table 3.
Do you have previous work or observation experiences in mental/behavioral health settings?

Yes	No	Not Sure
28.57%	57.14%	14.28%

undergraduate degrees among OTD and DPT students included exercise science (32.7%), psychology (24.5%), other related health sciences (14.3%), and biology (12.2%).

Among the participants who were OTD students, there were first-year students (n = 24) and second-year students (n = 21). The sample also included DPT students (n = 3) and unanswered (n = 1). Table 1 demonstrates the percentages of students per cohort. The findings from the demographic data revealed that 42.9% of OTD participants had completed a Level I psychosocial fieldwork rotation in either an inpatient/outpatient mental health or community setting (see Table 2) and 28.6% reported having previous experience in behavioral health before fieldwork and the current study (see Table 3). After receiving the lecture and completing the pre-test survey, approximately 55% of all participants (regardless of assigned instructional method) agreed or strongly agreed to the statement, "I feel confident in my ability to address a client's psychosocial factors during the therapy process in any clinical setting." Also, 38% of participants agreed or strongly agreed to the statement, "I feel confident in my ability to address a client's psychosocial factors during the therapy process in a mental/behavioral health setting." On the post-test, 75% and 80%, respectively, agreed to the above statements, demonstrating an increase in perceived confidence in addressing psychosocial factors from pre-test to post-test. Similarly, confidence increased approximately from 65% to 86% of participants agreeing or strongly agreeing to the statement, "I feel confident in my ability to my ability to work with a client who has been diagnosed with bipolar disorder." On the post-test, 57% of participants agreed with the statement, "this lesson makes me feel prepared to work as a therapist in a mental health setting, even if I do not have a Level II fieldwork/full-time clinical internship rotation in a mental health setting." However, instructional method was not a predictor of this response ($R = 0.196$, $p = 0.177$)

Analysis of Competence and Confidence

Participants were randomly distributed into the LEA (n = 16), PBL (n = 18), and standardized patient (n = 15). The participants' level of competence was measured using multiple-choice questions created by a registered OT practitioner. Students responded to ten Likert scale statements, rating confidence along a five-point scale (strongly agree to strongly disagree). Competence and confidence scores were calculated by summing the number of correctly chosen multiple choice answers out of nine possible and the sum of Likert responses out of 50 possible. One question (number 21, see Appendices B and C) was evaluated independently due to a wide

variety of correct responses that, if included in overall competence, would have skewed the data.

Two, two-way repeated measure analyses of variance (ANOVAs) were conducted to identify any potential differences between pre-test and post-test scores on confidence and competence across instructional methods. Two, two-way repeated measure ANOVAs were chosen as the most optimal analyses in order to reduce the likelihood of Type I error that might occur from completing several one-way ANOVAs or paired sample t-tests for each instructional method (3) and each pre-test/post-test (2).

The first two-way repeated measures ANOVA was conducted to determine a significant difference between student competence over time, with a within-subjects factor of time (pre-test and post-test scores) and between-subjects factor of instructional method (LEA, PBL, standardized patient). An additional two-way repeated measures ANOVA was conducted to determine a significant difference in student confidence over time with a within-subjects factor of time and between-subjects factor of instructional method. An additional two-way repeated measures ANOVA was conducted to determine whether any differences existed in pre-test and post-test competence scores across the three instructional methods.

Competence

There were two outliers, as assessed by a boxplot (see Figure 1), however, the outliers were not considered true outliers based on examination of studentized residuals (see Figures 2 and 3) did not indicate outliers. For the post-test, the data were normally distributed, as assessed by the Shapiro-Wilk test of normality ($p > .05$). There was homogeneity of variances ($p > .05$) and covariances ($p > .001$), as assessed by Levene's test and Box's M test, respectively. However, for pre-test competence, the data were not normally distributed, as assessed by the Shapiro-Wilk test of normality ($p < .05$). Based on the visual examination of QQ plots for the pre- and post-test (see Figure 2 and Figure 3), the data were close to normal, and the assumptions were met to conduct an ANOVA.

Results of ANOVA

There was no statistically significant interaction between the intervention and time on competence, $F(2, 46) = 2.333$, $p = 0.108$ (see Figure 4). There were no statistically significant main effects time points, $F(2, 46) = 1.826$, $p = 0.1$ (see Figure 5).

Confidence

There was one outlier, as assessed by a boxplot (see Figure 1). The outlier was retained in the dataset because examination of studentized residuals (see Figures 6 and 7) did not indicate outliers. The data were normally distributed, as assessed by Shapiro-Wilk's test of normality ($p > .05$). There was a homogeneity of variances ($p > .05$) and covariances ($p > .001$), as assessed by Levene's test of homogeneity of variances and Box's M test, respectively.

There was no statistically significant interaction between the intervention and time on confidence, $F(2, 46) = .74$, $p = .48$, partial $\eta 2 = .031$ (see Figure 8). The effect size for this analysis ($d = 0.6702$) was found to exceed Cohen's (1988) convention for a medium effect ($d = 0.5$), demonstrating that one instructional method did not significantly indicate a greater change in mean confidence from pre-test to post-test compared to the other instructional methods (see Figure 9). The main effect of time showed a statistically significant difference in mean confidence at the different time points, $F(2, 46) = 106.29$, $p < .001$, partial $\eta 2 = .698$. According to Cohen's (1988) standards, the effect size ($d = 1.5202$) exceeds an effect size of large effect ($d = 0.8$). These results indicate that confidence significantly increased from pre-test ($M = 32.80$, $SD = 5.17$) to post-test ($M = 38.35$, $SD = 4.151$). Similarly, the main effect showed that there was a statistically significant difference in mean confidence between intervention groups, $F(2, 46) = 5.39$, $p = .008$, partial $\eta 2 = .19$. The effect size for the analyses across groups over time ($d = 0.484$) exceeds Cohen's (1988) convention for a small effect size ($d = 0.2$). The standardized.

Figure 1.
Box Plot Confidence and Competence

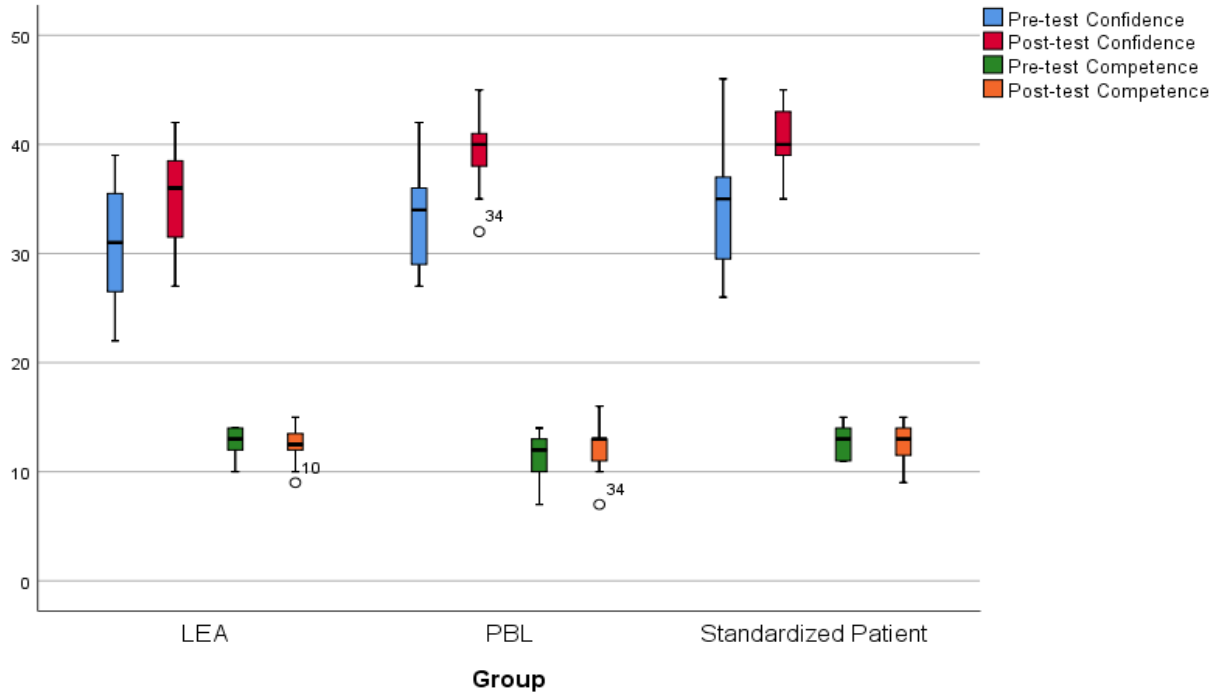


Figure 2.
QQ Plot for Pre-Test Competence

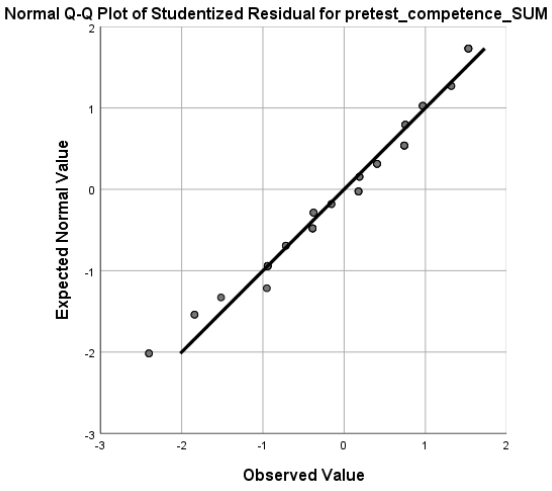
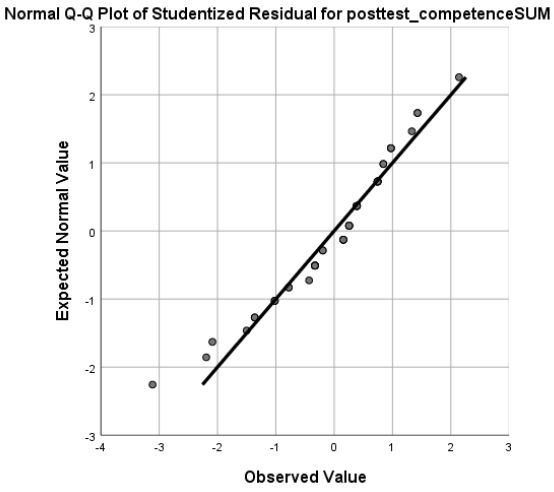


Figure 3.

QQ Plot for Post-Test Competence



https://doi.org/10.46409/001.BWXS8816

Figure 4.
Interaction Effect of Standardized Patient and LEA – Competence

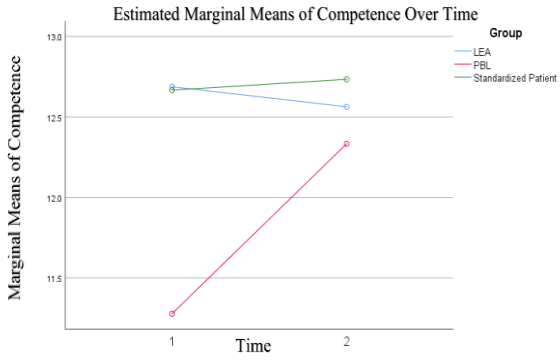


Figure 5.
Means for Competence Prior and Following Instructional Method

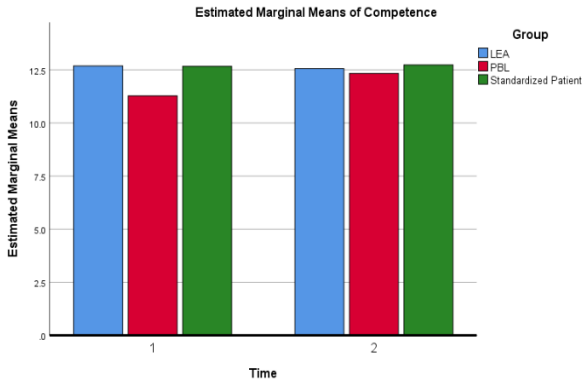


Figure 6.
QQ Plot for Pre-Test Confidence

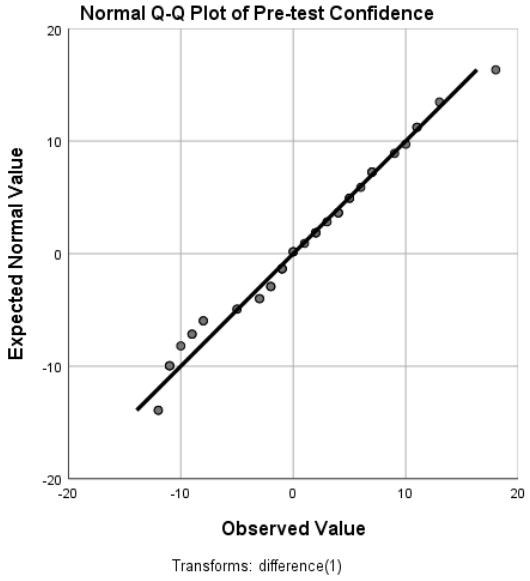
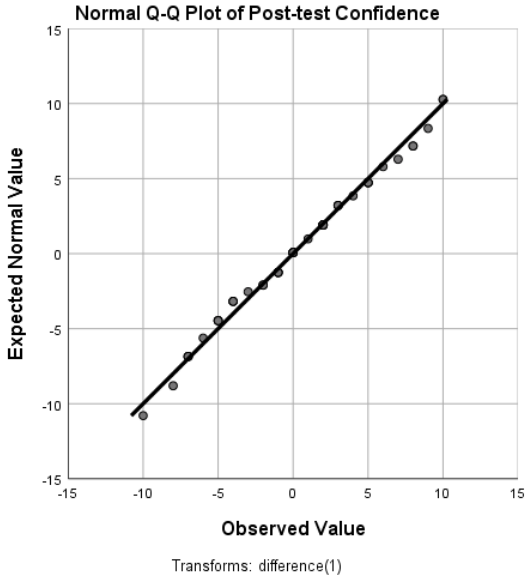


Figure 7.
QQ Plot for Post-Test Confidence



https://doi.org/10.46409/001.BWXS8816

Figure 8.
Interaction Effect of Standardized Patient and LEA – Confidence

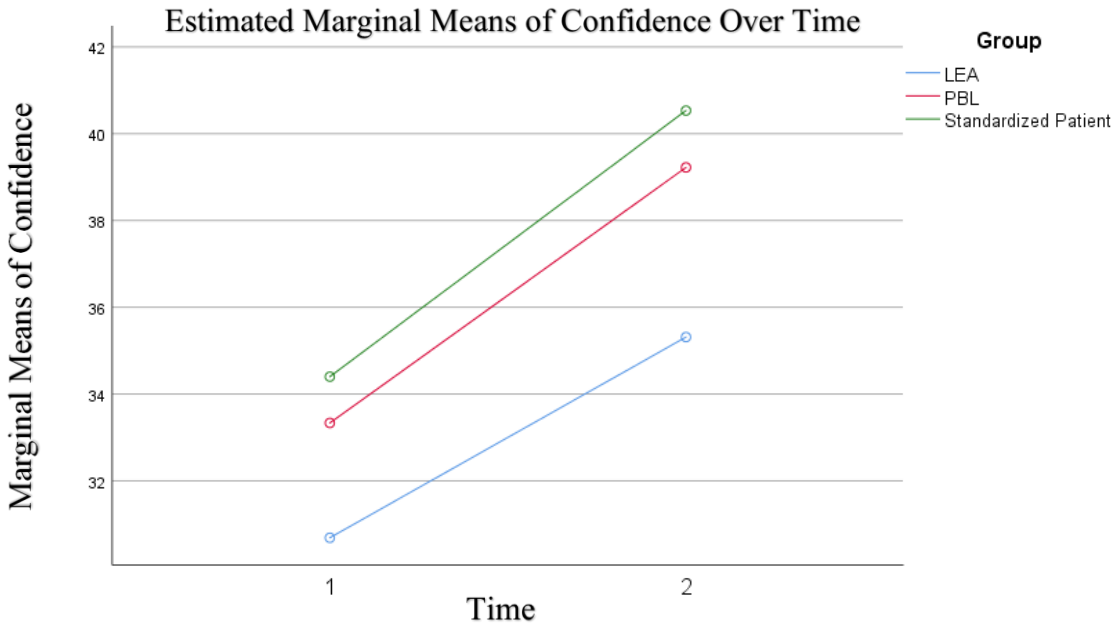
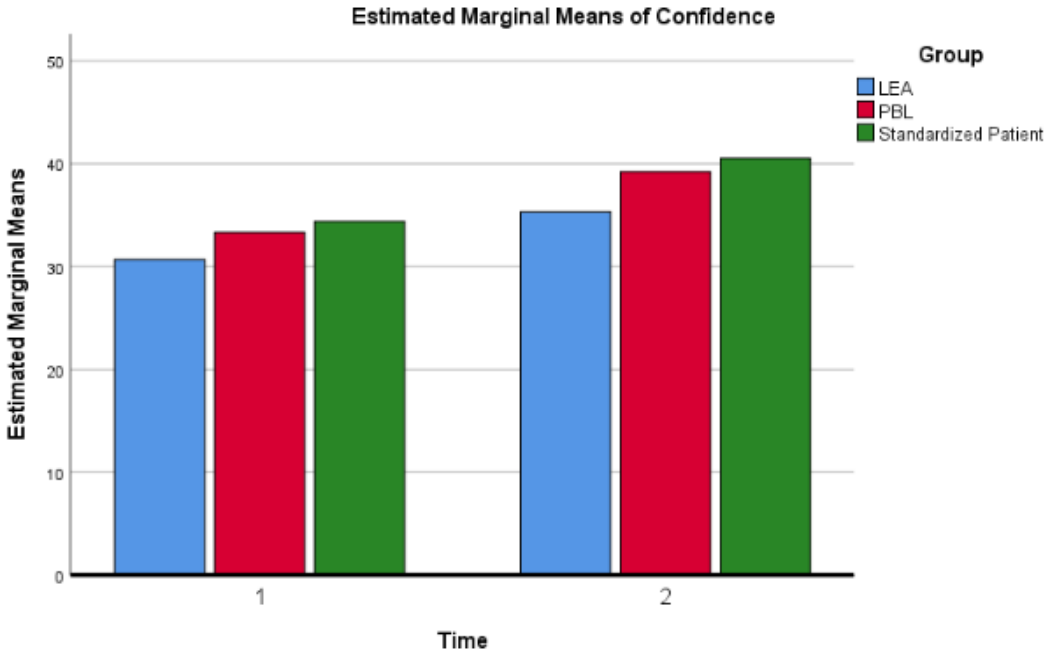


Figure 9.
Means for Pre-Test and Post-Test Confidence



https://doi.org/10.46409/001.BWXS8816

patient group was associated with a mean confidence score of 4.47, 95% CI [935, 8.0] higher than the LEA group, a statistically significant difference, $p < .009$.

First- and Second-Year Student Data

Among the OTD students, competence and confidence scores were analyzed to assess for differences between first- and second-year students. The comparison analysis only included first- and second-year OTD students due to the limited sample size of DPT students (n = 3). First-year student's mean confidence was higher across the pre-test (M = 34.19) and post-test (M = 39.24) compared to second-year student's confidence across pre-test (M = 31.79) and post-test (M = 37.88). A mixed ANOVA analysis was conducted and revealed no significant interaction between instructional method and specific cohort on post-test competence ($F(7, 34) = 0.137$, p = 0.372) nor post-test confidence ($F(7, 34) = 0.508$, p = 0.822). When participants were grouped into first- and second-year students, a mixed repeated measures ANOVA revealed no significant interactions between time and year of school on competence ($F(2, 45) = 0.437$, p = 0.648) and confidence ($F(2, 45) = 1.147$, p = 0.327). No main effects of cohorts were significant for competence ($F(2, 45) = 1.662$, p = 0.20) and confidence ($F(2, 45) = 1.179$, p = 3.17).

Discussion

A case-series study was conducted to explore the relationship between three instructional methods and student competence and confidence in providing occupational therapy services in a behavioral health setting. The study was conducted in response to the revision of the Accreditation Council for Occupational Therapy Education fieldwork objective C.1.9, including additional instructional methods to satisfy the current Level I fieldwork requirement (AOTA, 2019).

Competence

Competence questions required clinical problem solving; effectively applying definitions that commonly arise in behavioral health, differentiating between psychosocial, behavioral health, and mental health characteristics; and demonstrating an understanding of best practices. Individual instructional methods and time did not significantly interact to affect competence. Overall, these results suggest that competence did not significantly change over time between the administration of the pre-test and post-test, regardless of the instructional method. However, the use of alternative instructional methods could reveal some clinical significance in increasing student competence over time. With limited insight into how the instructional methods affect competence, results indicate the need for more effective methods to measure competence. The participants were also only exposed to one instructional method; therefore, the lack of significance may indicate a need for more exposure to one or more instructional methods before displaying competence.

Confidence

Comparable to the results involving competence, instructional method and time did not significantly interact to affect confidence. However, instructional method and time individually showed significant effects on confidence. Between the administration of pre-test and post-test, confidence significantly increased, regardless of instructional method. Additionally, participants in the standardized patient group scored higher on confidence compared to the participants in the LEA group, regardless of time.

This result might be interpreted in multiple ways. Because confidence increased from pre-test to post-test across groups, it could be interpreted that the standardized patient group showed a more considerable change than LEA, and with a larger sample size and more data points, an interaction might occur between group and time. However, this interpretation cannot be given with certainty because there was no significant interaction with time. It could also be deduced that the standardized patient group was inherently different from LEA, resulting from chance, as the participants were randomly distributed, and cohorts were primarily equal across groups. The

standardized patient group was also potentially different because, though the simulation reflected the case study, the individual presented with manic symptoms. While the standardized group was much higher in confidence than the LEA, the LEA method might have been inherently different to result in much lower confidence. The LEA group involved a personal experience of a bipolar disorder diagnosis, making it less controlled. Additionally, the LEA group was virtual while the standardized patient was in person, which could have decreased its effect on confidence. More research must be conducted to determine the true effect of the standardized patient and LEA on confidence.

Psychosocial vs. Behavioral Health

With the recent changes to the ACOTE Level I fieldwork standards, the call to ensure OT students can distinguish between psychosocial factors and behavioral health becomes more vital prior to entering Level II fieldwork placements. The new fieldwork requirements may facilitate curriculum on OT interventions to address behavioral health problems. Participants were asked to distinguish between psychosocial and behavioral/mental health in the competence question section. Participants demonstrated a mixed understanding of the differences, both after receiving the lecture and the instructional method. For example, Table 4 shows that, while hypomania is considered a behavioral health factor, more participants answered incorrectly following the post-test. On the other hand, determination is a psychosocial factor, and more participants answered correctly following the post-test. When examining the frequency data for distinguishing psychosocial factors, the wide variability of correct responses existed not only across factors but over time as well. The responses suggest that participants did not have a strong understanding and retention of the definition of psychosocial, a key concept within the fieldwork curriculum and in the role of OT across practice settings.

Over time, Likert scale results revealed perceived confidence in applying interventions in a mental/behavioral health setting increased compared to any clinical setting, contrasting the results reported in the pre-test. However, due to the mixed levels of competence in distinguishing between psychosocial and behavioral health factors, the reported confidence might not be beneficial. Overall, understanding the unique value of psychosocial and behavioral health factors plays a key role in student preparedness.

Table 4.
Which of the following would be considered psychosocial factors? Select all that apply.

	Pre-Test (% correct)	Post-Test (% correct)
Decreased Confidence*	87.8	93.9
Loneliness*	95.9	100.0
Determination*	61.2	73.5
Hallucinations	67.3	67.3
Denial*	71.4	73.5
Hypomania	59.2	42.9
Hopelessness*	87.8	89.8
Depression	69.4	69.4

**correct psychosocial factors*

https://doi.org/10.46409/001.BWXS8816

Limitations

Participants

Limitations should be noted in the review of the current study. First, the study was completed based on a small convenience sample, limiting a representative distribution of the population and generalizability.

Instruments

Following data analyses, the researchers attempted a factor analysis on the instruments used to measure competence and confidence to explore whether the assessment was reliable. Reliability analyses revealed low internal reliability for the ten competency statements ($\alpha = 0.329$), suggesting that competence was not effectively measured. However, reliability analyses for confidence revealed strong internal reliability for the ten confidence statements ($\alpha = 0.816$), suggesting the instrument was reliable in assessing confidence. By not being able to measure competence and confidence effectively, generalizability and the ability to conduct a thorough analysis of the results are limited.

Lastly, the study relied on the notion that preparedness for working in behavioral health is solely dependent on competence and confidence. Competence and confidence may not be the proper variables required for measuring preparedness for clinical practice.

Procedures

Participants were recruited via fliers that advertised the study as an exploration of mental health and OT, which may have inadvertently attracted participants with a specific interest in mental health and skewed competence and confidence scores.

Due to unforeseen technical difficulties with the virtual data collection assistant, electronic surveys were not able to be submitted or reviewed; therefore, pre- and post-test hard copies were distributed, prompting some participants to complete the pre-test twice, despite instructions not to do so. The circumstance could have allowed participants to change initial responses, skewing the final data.

The faculty member who led the simulation was a research team member who had knowledge of the study objectives. Therefore, potential bias could have occurred during the standardized patient instructional method. Although the standardized patient simulation and the PBL case study were based on information from the LEA, discrepancies in presentation and explanation of symptoms may have varied between the instructional methods, which could have influenced answer selections during the post-test. Additionally, A “practice effect” may have occurred from participants answering the same competence and confidence questions in both the pre-test and the post-test, potentially resulting in decreased validity of the data.

The outliers identified through the box plot were not identified as true outliers following the studentized residual. Thus, the data met the assumptions of the ANOVA. Due to this finding, non-parametric testing was not conducted, resulting in a possible limitation.

Generalizability of this study is limited by the fact that the instructional methods were based on one diagnosis – bipolar disorder – restricting the participants’ experience compared with the variety and complexity of diagnoses and situations an OT would address in a mental health setting. Further research is warranted to broaden the study and explore the relationship with additional diagnoses.

Conclusion

This study's limitations support the need for further research regarding the role of OT in mental health and how best to prepare students for clinical fieldwork experiences. The current study evaluated the relationship of an LEA, PBL, and use of standardized patients on perceived student competence and confidence to provide OT services in behavioral health settings. Analyses revealed no significant effect of the instructional method and no significant interactions on

competence. However, the data did reveal significant main effects of group and time on confidence. Confidence increased across all instructional methods and exhibited a significant difference between the LEA and standardized patient. This study is an provides important data regarding instructional methods used in response to recent ACOTE changes to best educate and prepare students. It addresses different instructional methods and poses a new avenue to improve curriculum within OT programs concerning mental health.

Additionally, this study is unique in attempting to measure preparedness through competence and confidence, which may lead to further research. By developing a reliable measurement of competence and confidence, OT programs will have an objective measure of curriculum effectiveness. Similarly, longitudinal research is recommended to determine which instructional methods have a significant effect on student preparedness. With more research related to the current study, OT programs can better prepare students to be confident and competent entry-level OT practitioners within mental and behavioral health.

References

Accreditation Council for Occupational Therapy Education. (2018). 2018 Accreditation council for occupational therapy education standards and interpretive guide. *American Journal of Occupational Therapy, 72*(Suppl. 2), 1-83. https://doi.org/10.5014/ajot.2018.72S217

American Occupational Therapy Association. (2019). *2018 Accreditation Council for Occupational Therapy Education (ACOTE®) Standards and Interpretive Guide*. https://acoteonline.org/wp-content/uploads/2020/10/2018-ACOTE-Standards.pdf

Blackwell, C. & Bilics, A. (2017). Preparing occupational therapy students to address mental health promotion, prevention, and intervention in school-based practice. *Journal of Occupational Therapy, Schools, & Early Intervention, 11*, 1-10. https://doi.org/10.1080/19411243.2017.1386605

Breines, E. (1987). Pragmatism as a foundation for occupational therapy curricula. *American Journal of Occupational Therapy, 41*(8), 522–525. https://doi.org/10.5014/ajot.41.8.522

Brown, C. & Stoffel, V. C. (2011). *Occupational therapy in mental health: A vision for participation.* F.A. Davis Company.

Byrne, L. (2013). *A grounded theory study of lived experience mental health practitioners within the wider workforce* (Doctoral dissertation). https://acquire.cqu.edu.au/articles/thesis/A_grounded_theory_study_of_lived_experience_mental_health_practitioners_within_the_wider_workforce/13387079

Cohn, E. S. (2019). Asserting our competence and affirming the value of occupation with confidence. *American Journal of Occupational Therapy, 73*(6). https://doi.org/10.5014/ajot.2019.736002

Cohen, J. (1988), Statistical Power Analysis for the Behavioral Sciences, 2nd Edition. Hillsdale, N.J.: Lawrence Erlbaum.

Creek, J. & Lougher, L. (2008). *Occupational therapy and mental health* (4th ed.). Elsevier.

Crowe, M., & Mackenzie, L. (2002). The influence of fieldwork on the preferred future practice areas of final year occupational therapy students. *Australian Occupational Therapy Journal*, *49*, 25-36. https://doi.org/10.1046/j.0045-0766.2001.00276.x

Dickinson, T., Hopton, J., & Pilling, M. (2016). An evaluation of nursing students' perceptions on the efficacy of high-fidelity clinical simulation to enhance their confidence, understanding and competence in managing psychiatric emergencies. *Journal of Clinical Nursing*, *25*(9-10), 1476-1478. https://doi.org/10.1111/jocn.13211

Evenson, M. (2011). Preparing for fieldwork: Students' perceptions of their readiness to provide evidence-based practice. *IOS press*, *44*, 297-306. https://doi.org/10.3233/WOR-121506

Giles, A. K., Carson, N. E., Breland, H. L., Coker-Bolt, P., & Bowman, P. J. (2014). Use of simulated patients and reflective video analysis to assess occupational therapy students' preparedness for fieldwork. *American Journal of Occupational Therapy*, *68*(S2), S57-66. https://doi.org/10.5014/ajot.2014.685S03

Happell, B., Bennetts, W., Harris, S., Platania-Phung, C., Tohotoa, J., Byrne, L., & Wynaden, D. (2015). Lived experience in teaching mental health nursing: Issues of fear and power. *International Journal of Mental Health Nursing*, *24*, 19-27. https://doi.org/10.1111/inm.12091

Ikiugu, M. N., & Schultz, S. (2006). An argument for pragmatism as a foundational philosophy of occupational therapy. *Canadian Journal of Occupational Therapy*, *73*(2), 86–97. https://doi.org/10.2182/cjot.05.0009

Knecht-Sabres, L. J., Kovic, M., Wallingford, M., & St. Amand, L. E. (2013). Preparing occupational therapy students for the complexities of clinical practice. *Open Journal of Occupational Therapy*, *1*(3). https://doi.org/10.15453/2168-6408.1047

Martikainen, P., Bartley, M., & Lahelma, E. (2002). Psychosocial determinants of health in social epidemiology. *International Journal of Epidemiology*, *31*, 1091–1093. https://doi.org/10.1093/ije/31.6.1091

McGee, C., & Sopeth, L. (2015). Occupational therapy student learning in acute care contexts: Blending online, classroom, simulation, and fieldwork education. *American Journal of Occupational Therapy*, *69*, 879–882. https://doi.org/10.5014/ajot.2015.69S1-RP401

National Board for Certification in Occupational Therapy. (2018). *Practice analysis of the occupational therapist registered- Execute summary* [PDF file]. NBCOT. https://www.nbcot.org/-/media/NBCOT/PDFs/2017-Practice-Analysis-Executive-OTR.ashx?la=en&hash=42CC69FEB1F23F480B90A733E031DAEB5D5AD1FD

Omari Pittman, C., & Lawdis, K. (2017). Does the use of multifactorial training methods increase practitioners' competence? *Journal of Educators Online*, *14*(2). http://doi.org/10.9743/jeo.2017.14.2.2

Quail, M., Brundage, S., Spitalnick, J., Allen P., Beilby, J. (2016). Student self-reported communication skills, knowledge and confidence across standardised patient, virtual and traditional clinical learning environments. *BMC Medical Education*, *16*(73). https://doi.org/10.1186/s12909-016-0577-5

Ridley, S., Martin, R., & Mahboub, L. (2017). Learning from mental health lived experience and the influence on students' practice.

Australian Social Work, *70*(3), 372–380. https://doi.org/10.1080/0312407X.2016.1235718

Rodger, S., Fitzgerald, C., Davila, W., Millar, F., & Allison, H. (2011). What makes a quality occupational therapy practice placement? Students' and practice educators' perspectives. *Australian Occupational Therapy Journal, 58*, 195-202. https://doi.org/10.1111/j.1440-1630.2010.00903.x

Rowe, M. Frantz, J., & Bozalek, V. (2012) The role of blended learning in the clinical education of healthcare students: A systematic review. *Medical Teacher*, *34*(4). https://doi.org/10.3109/0142159X.2012.642831

Scaffa, M. & Wooster, D. (2004). Effects of problem-based learning on clinical reasoning in occupational therapy. *The American Journal of Occupational Therapy*, *58*(3), 333-336. https://doi.org/10.5014/ajot.58.3.333

Schaber, P., Wilcox, K., Whiteside, A. L., Marsh, L., & Brooks, C. D. (2010). Designing learning environments to foster affective learning: Comparison of classroom to blended learning. *International Journal for the Scholarship of Teaching and Learning*, *4(*2). https://doi.org/10.20429/ijsotl.2010.040212

Swarbrick, M., & Noyes, S. (2018). Effectiveness of occupational therapy services in mental health practice. *The American Journal of Occupational Therapy*, *72*. https://doi.org/10.5014/ajot.2018.725001

Substance Abuse and Mental Health Administration. (2014). *National Framework for Quality Improvement in Behavioral Health Care* [PDF File]. https://www.nasmhpd.org/sites/default/files/SAMHSA%20Quality%20Improvement%20Initiative.pdf

Appendix A: Consent Form

Statement of Informed Consent

DISCLOSER STATEMENT: The following study involves topics surrounding mental/behavioral health and may be emotionally distressing to some participants. All participation is voluntary, and participants can withdraw from the study at any time.

I have been asked to participate as a subject in a research project entitled:
OTD Student Preparedness for Applying Interventions in Behavioral Health Settings
This project is under the direction of Dr. Sara Best, faculty at Huntington University, as a component of the Doctorate of Occupational Therapy Program's research course, OTD 732: Research IV: Design. The supervising professor can be contacted at the following number: 260-702-9625 The Huntington University Institutional Review Board Chair, Dr. Mike Rowley, can be contacted at 260-359-4277 for any questions pertaining to the research.

- I understand that I will be asked to participate in an online survey after a lecture and I may elect to participate in a instructional method at a later date.
- I understand that there are minimal associated risks with participating in this project. These risks may include emotional distress due to the nature of the lecture topic, the instructional method to which I am assigned, and/or questions in the test and survey.
- I understand that at any point in time I may withdrawal myself from the study, and that any data I have provided will be excluded from the data analysis.
- I understand that information gathered from me during this project will not be reported to nor shared with anyone outside the project team in any manner which might allow someone to identify me. A confidential number will be assigned to each individual participating in the survey and instructional method to protect individual identities.
- I understand that report of combined and generalized results involving multiple participants will be prepared and may be presented for educational purposes only. I understand that results of this study may be submitted for professional publication and/or presentation.
- **I understand that some information shared today is based off of real individuals and must remain confidential. I understand that I cannot share any information about the discussions today.**

My signature indicates that I understand and voluntarily agree to the conditions of participation described above and that I may withdraw from the study at any time.

_____ _____
Printed Name Date

_____
Signature

_____ _____
Parent/Guardian Signature (if under 18 years old) Date

https://doi.org/10.46409/001.BWXS8816

Appendix B: Pretest Survey

Pre-and Post-Test

Demographic Information

Questions	**Answers**
What is your ID number?	
Age	
Gender Identity	

Background Information

Questions	**Answers**
Undergraduate Degree	Psychology Exercise Science Kinesiology Recreational Therapy Nursing Art/Music Social Work/Human & Family Services Early Childhood Development/ Education Biology Biochemistry/Chemistry Other health sciences/medical/therapy not listed Other liberal arts not listed
Are you currently enrolled in the institution's Doctorate of Occupational Therapy Program?	Yes No
Of which cohort do you belong?	Fall cohort, class of 2021 Spring cohort, class of 2021 Fall cohort, class of 2022 Spring cohort, class of 2022 DPT Student
Did you participate in the "Mental Health in OT" survey or focus group during the institute's qualitative course (Summer 2019)	Yes No
Have you completed the institute's psychosocial fieldwork rotation?	Yes No
In what setting did your psychosocial rotation take place?	Inpatient/Outpatient Mental Health Community Setting Not Applicable

In which settings do you hope to complete your Level II fieldwork? (check all that apply)	Acute Care Behavioral Health Community-Based Corrections/Juvenile Detention Home Health Inpatient Rehab Facility Other Outpatient/Hand Therapy Pediatrics/ School Skilled Nursing Facility
Do you have previous work or observation experiences in mental/behavioral health settings?	Yes No Not sure

Assessment of Perceived Confidence and Competency

Questions	**Answers**
After the lesson on occupational therapy in Mental Health and Bipolar Disorders, I feel ***confident*** *in…*	
… understanding how to use therapeutic use of self with clients in a therapeutic relationship.	Strongly Disagree Disagree Neutral Agree Strongly Agree
… addressing a client's psychosocial factors during the therapy process in any clinical setting.	Strongly Disagree Disagree Neutral Agree Strongly Agree
… addressing a client's psychosocial factors during the therapy process in a mental/behavioral health setting.	Strongly Disagree Disagree Neutral Agree Strongly Agree
… helping clients to accept new functional deficits when they experience depression, anxiety, anger, and other maladaptive emotional responses following illness or injury.	Strongly Disagree Disagree Neutral Agree Strongly Agree
… my ability to assess the impact of bipolar disorder on a client's occupations.	Strongly Disagree Disagree Neutral Agree Strongly Agree

https://doi.org/10.46409/001.BWXS8816

… my ability to work with a client who has been diagnosed with bipolar disorder.	Strongly Disagree Disagree Neutral Agree Strongly Agree
… my ability to develop long- and short-term goals for a client with bipolar disorder.	Strongly Disagree Disagree Neutral Agree Strongly Agree
… my ability to develop and implement evidence-based interventions for a client who has bipolar disorder.	Strongly Disagree Disagree Neutral Agree Strongly Agree
This lesson makes me feel prepared to work as a therapist in a mental health setting, even if I do not have a Level II fieldwork/full-time clinical internship rotation in a mental health setting.	Strongly Disagree Disagree Neutral Agree Strongly Agree
This lesson, along with my Level I fieldwork/CARE experience, makes me feel prepared to work as a therapist in a mental health setting. (If you have not yet completed the psychosocial Level I fieldwork experience, select "Neutral")	Strongly Disagree Disagree Neutral Agree Strongly Agree

Knowledge Assessment

Questions	**Answers**
Which of the following would be considered psychosocial factors? Select all that apply.	Decreased confidence Loneliness Determination Hallucinations Denial Hypomania Hopelessness Depression
You are about to evaluate a new patient, who has recently undergone right lower extremity, below-knee amputation. The patient refuses therapy, stating, "I can't even walk anymore, what's the point?" Which of the following is the *most appropriate* example of using therapeutic use of self in this situation?	"I'm sorry you feel that way, but you really can do more than you think you can." "This is a lot to deal with. Besides mobility, what other things are you concerned about not being able to do now?" "The doctor wrote an order for therapy, so we have to at

	least try!" "Are you feeling suicidal? I can have someone come in and talk to you." "A lot of people have this type of amputation. Let's look at some options for wheelchairs to get you moving around independently again."
Therapeutic use of self is	the way in which the OT uses their own verbal and non-verbal communication skills, empathy, and clinical reasoning to develop a collaborative relationship with clients. the way in which the OT uses components of cognitive-behavioral therapy and interpersonal psychotherapy to help a client accept their new level of function. a specific therapeutic technique which requires special training in order to use with clients diagnosed with a bipolar disorder. only appropriate to use with clients with mental health disorders.
A client who has had surgery to repair rotator cuff damage in his right shoulder has just been told that he will not be able to play baseball this season. Though the client has not been officially diagnosed with a mental illness, he is exhibiting symptoms of depression and asks, "what am I supposed to do all summer?" The client is experiencing problems with:	mental health behavioral health psychosocial factors both mental health and behavioral health both mental health and psychosocial factors both behavioral health and psychosocial factors
A client with bipolar disorder is worried about losing her job due to several days missed during depressive episodes. The therapist can help the client	Develop strategies for increasing motivation to get out of bed and go to work during depressive episodes Come up with ways to tell her boss that she has bipolar disorder, so he understands why she calls out of work Look for a job that offers more sick time Ask her boss for less responsibility at work so there is less impact on the company when she isn't there
A client with bipolar disorder is having difficulty focusing on a schedule-making task during occupational therapy. She is easily distracted, jumps from topic to topic in conversation, and is having a difficult time sitting still. The occupational therapist (OT) determines that the client is experiencing a manic episode. The OT	Giving the client constant verbal reminders to redirect back to the task Offer to let the client choose a more preferred activity if they can successfully finish the schedule-making task

could address this by	Point out that the client appears distracted, ask how this decreased attention is affecting the client, and have the client identify strategies for staying on task End the therapy session and suggest that the client reschedule when manic symptoms have decreased
A new client with bipolar disorder has just moved to this city and started a new job. It is his first time living outside of his hometown, and he is worried about being able to manage his manic and depressive episodes without his friends and family nearby. A first step that the therapist might take would be to	Have the client identify dates when he can visit his hometown Help the client make a list of local activities to help motivate him during depressive episodes Research local support groups and activities in which the client is interested, and have the client make a goal to participate in one before next week's OT session Have the client make a goal to introduce himself to three of his neighbors before the next OT session
An OT is evaluating a new client who is diagnosed with a bipolar disorder. The client is having difficulty identifying goals for leisure activities, stating "when I'm depressed, I don't want to do anything, let alone anything fun." How might the OT proceed?	Have the client identify other areas of occupation which are affected by depressive and manic episodes Rephrase the question using the client's own words, and ask which activities he considers "fun" Explain to the client the importance of leisure activities in maintaining mental health Suggest that the client make a list of activities that someone else might consider "fun", then have the client choose one from the list to develop a goal for participation
A client with bipolar disorder is experiencing a manic episode, and states that she wants to quit her job and travel the country, writing a travel blog to earn money. When the OT asks how much a travel blogger makes and would it be enough to cover expenses, the client states that she would "figure it out" as she goes. The OT knows that the client is already having financial difficulties, and that this idea is impulsive and would probably be more detrimental than helpful. The OT should	Have the client research a profession other than travel-blog writing which would be more financially lucrative Have the client list all of the reasons that this may not be a good idea Have the client list her current expenses and research the costs and expenses of traveling to see if it is a viable goal Remind the client of her current financial state by showing her the treatment note for the session in which the client admitted to having financial problems
A client with bipolar disorder admits that he feels like his friends and family cannot relate to him because of his mental illness, and that he often feels isolated and alone. This client is describing issues with	mental health behavioral health

	psychosocial factors both mental health and behavioral health both mental health and psychosocial factors both behavioral health and psychosocial factors

Any Additional Comments

https://doi.org/10.46409/001.BWXS8816

Spring 2021
ISSN: 2689-1662

Appendix C: Posttest Survey

ID NUMBER:

Assessment of Perceived Confidence and Competency

Questions	**Answers**
After the lesson on occupational therapy in Mental Health and Bipolar Disorders, I feel ***confident*** *in…*	
… understanding how to use therapeutic use of self with clients in a therapeutic relationship.	Strongly Disagree Disagree Neutral Agree Strongly Agree
… addressing a client's psychosocial factors during the therapy process in any clinical setting.	Strongly Disagree Disagree Neutral Agree Strongly Agree
… addressing a client's psychosocial factors during the therapy process in a mental/behavioral health setting.	Strongly Disagree Disagree Neutral Agree Strongly Agree
… helping clients to accept new functional deficits when they experience depression, anxiety, anger, and other maladaptive emotional responses following illness or injury.	Strongly Disagree Disagree Neutral Agree Strongly Agree
… my ability to assess the impact of bipolar disorder on a client's occupations.	Strongly Disagree Disagree Neutral Agree Strongly Agree
… my ability to work with a client who has been diagnosed with bipolar disorder.	Strongly Disagree Disagree Neutral Agree Strongly Agree
… my ability to develop long- and short-term goals for a client with bipolar disorder.	Strongly Disagree Disagree Neutral Agree Strongly Agree

https://doi.org/10.46409/001.BWXS8816

Spring 2021
ISSN: 2689-1662

… my ability to develop and implement evidence-based interventions for a client who has bipolar disorder.	Strongly Disagree Disagree Neutral Agree Strongly Agree
This lesson makes me feel prepared to work as a therapist in a mental health setting, even if I do not have a Level II fieldwork/full-time clinical internship rotation in a mental health setting.	Strongly Disagree Disagree Neutral Agree Strongly Agree
This lesson, along with my Level I fieldwork/CARE experience, makes me feel prepared to work as a therapist in a mental health setting. (If you have not yet completed the psychosocial Level I fieldwork experience, select "Neutral")	Strongly Disagree Disagree Neutral Agree Strongly Agree

Knowledge Assessment

Questions	**Answers**
Which of the following would be considered psychosocial factors? Select all that apply.	Decreased confidence Loneliness Determination Hallucinations Denial Hypomania Hopelessness Depression
You are about to evaluate a new patient, who has recently undergone right lower extremity, below-knee amputation. The patient refuses therapy, stating, "I can't even walk anymore, what's the point?" Which of the following is the *most appropriate* example of using therapeutic use of self in this situation?	"I'm sorry you feel that way, but you really can do more than you think you can." "This is a lot to deal with. Besides mobility, what other things are you concerned about not being able to do now?" "The doctor wrote an order for therapy, so we have to at least try!" "Are you feeling suicidal? I can have someone come in and talk to you." "A lot of people have this type of amputation. Let's look at some options for wheelchairs to get you moving around independently again."
Therapeutic use of self is	the way in which the OT uses their own verbal and non-verbal communication skills, empathy, and clinical reasoning to develop a collaborative relationship with clients.

	the way in which the OT uses components of cognitive-behavioral therapy and interpersonal psychotherapy to help a client accept their new level of function. a specific therapeutic technique which requires special training in order to use with clients diagnosed with a bipolar disorder. only appropriate to use with clients with mental health disorders.
A client who has had surgery to repair rotator cuff damage in his right shoulder has just been told that he will not be able to play baseball this season. Though the client has not been officially diagnosed with a mental illness, he is exhibiting symptoms of depression and asks, "what am I supposed to do all summer?" The client is experiencing problems with	mental health behavioral health psychosocial factors both mental health and behavioral health both mental health and psychosocial factors both behavioral health and psychosocial factors
A client with bipolar disorder is worried about losing her job due to several days missed during depressive episodes. The therapist can help the client	Develop strategies for increasing motivation to get out of bed and go to work during depressive episodes Come up with ways to tell her boss that she has bipolar disorder, so he understands why she calls out of work Look for a job that offers more sick time Ask her boss for less responsibility at work so there is less impact on the company when she isn't there
A client with bipolar disorder is having difficulty focusing on a schedule-making task during occupational therapy. She is easily distracted, jumps from topic to topic in conversation, and is having a difficult time sitting still. The OT determines that the client is experiencing a manic episode. The OT could address this by	Giving the client constant verbal reminders to redirect back to the task Offer to let the client choose a more preferred activity if they can successfully finish the schedule-making task Point out that the client appears distracted, ask how this decreased attention is affecting the client, and have the client identify strategies for staying on task End the therapy session and suggest that the client reschedule when manic symptoms have decreased
A new client with bipolar disorder has just moved to this city and started a new job. It is his first time living outside of his hometown, and he is worried about being	Have the client identify dates when he can visit his hometown

able to manage his manic and depressive episodes without his friends and family nearby. A first step that the therapist might take would be to	Help the client make a list of local activities to help motivate him during depressive episodes Research local support groups and activities in which the client is interested, and have the client make a goal to participate in one before next week's OT session Have the client make a goal to introduce himself to three of his neighbors before the next OT session
An OT is evaluating a new client who is diagnosed with a bipolar disorder. The client is having difficulty identifying goals for leisure activities, stating "when I'm depressed, I don't want to do anything, let alone anything fun." How might the OT proceed?	Have the client identify other areas of occupation which are affected by depressive and manic episodes Rephrase the question using the client's own words, and ask which activities he considers "fun" Explain to the client the importance of leisure activities in maintaining mental health Suggest that the client make a list of activities that someone else might consider "fun", then have the client choose one from the list to develop a goal for participation
A client with bipolar disorder is experiencing a manic episode, and states that she wants to quit her job and travel the country, writing a travel blog to earn money. When the OT asks how much a travel blogger makes and would it be enough to cover expenses, the client states that she would "figure it out" as she goes. The OT knows that the client is already having financial difficulties, and that this idea is impulsive and would probably be more detrimental than helpful. The OT should	Have the client research a profession other than travel-blog writing which would be more financially lucrative Have the client list all of the reasons that this may not be a good idea Have the client list her current expenses and research the costs and expenses of traveling to see if it is a viable goal Remind the client of her current financial state by showing her the treatment note for the session in which the client admitted to having financial problems
A client with bipolar disorder admits that he feels like his friends and family cannot relate to him because of his mental illness, and that he often feels isolated and alone. This client is describing issues with	mental health behavioral health psychosocial factors both mental health and behavioral health both mental health and psychosocial factors both behavioral health and psychosocial factors

Any Additional Comments

Appendix D: PBL Handout

Case Study

Client is a 38-year-old female, and mother of two sons, diagnosed with Bipolar Type II Disorder seven years ago. Initially, symptoms were overlooked by medical professionals until she sought help from a counselor, following her divorce, who officially diagnosed her with Bipolar Type II Disorder. Her symptoms include a deep state of depression, rapid speech, avoidance of sleep, and never getting tired with four to seven days of no sleep. She has a tendency to become highly irritable, easily upset, and cries often. During her depressive state, she withdrawals from family, friends, responsibilities, and has trouble with simple tasks such as taking her dog out, showering, and cleaning. Her current coping strategies include medication management, cognitive strategies, social support, and, recognizing the present symptoms. Client utilizes stress management as her primary coping skill. She chooses to take more time to complete tasks and is conscious of the potential impact that symptoms can have on her daily routine. The client also uses social support as a coping strategy, in which her family went to counseling sessions with her to be educated on her diagnosis. Her loved ones also hold her accountable when she exhibits intense emotions. Medication management is critical to regulate symptoms and minimize the side effects during the adjustment period. Client reported having to take off work for two weeks while adjusting to new medication or after receiving a change in dosage. When the client is experiencing severe states, she sees her counselor once a week. When her symptoms are stable, she checks in with her counselor every few months or during stressful times.

What other information do you need from this patient?

What common symptoms does the client experience?

If the client said her coping strategies were not working, what would you recommend?

What occupations are impacted by the client's diagnosis?

What assessments would you utilize to evaluate the client during their first visit?

What interventions would you recommend using to improve the client's ability to engage in meaningful occupations?

https://doi.org/10.46409/001.BWXS8816

Spring 2021
ISSN: 2689-1662

Appendix E: Standardized Patient Handout

Standardized Patient Discussion

What other questions do you have for the patient?

What common symptoms does the client experience?

What coping strategies does the client utilize?

What occupations are impacted by the client's diagnosis?

What assessments would you utilize to evaluate the client during their first visit?

What interventions would you recommend using to improve the client's ability to engage in meaningful occupations?

https://doi.org/10.46409/001.BWXS8816

Spring 2021
ISSN: 2689-1662